APPLICATION FOR AIR AMBULANCE PROVIDER CERTIFICATION

INSTRUCTIONS: (PLEASE TYPE OR PRINT CAREFULLY)

1. Complete all items and questions. Attach additional pages if necessary.
2. Submit this form with all attachments, listing number and title of each item, to the EMS Commission, 302 W. Washington Street, Room E208, Indianapolis, Indiana 46204, 1-800-666-7784.
3. Upon completion, this form will be treated as a public record.

____Initial _____Renewal

TYPE OF AIR AMBULANCE (Check all that apply)

_____ Rotocraft ____Fixed-wing

Name of Provider		County	Certification Number
Mailing Address (City, State, Zip)		Street Address (City, State, Zip)	
Business Telephone Number		Dispatch (non-emergency) Telephone Number	
Name of Chief Executive Officer	Title	Telephone Number of CEO	E-Mail Address
Name of Medical Director	License Number	Telephone Number of MD	E-Mail Address
Address of Medical Director (Street, City, State, Zip)			
Name of Person Responsible for Day to Day Operations		Daytime Telephone Number	E-Mail Address
Name of Training Officer		Daytime Telephone Number	E-Mail Address
Name of Person Responsible for Data Collection		Daytime Telephone Number	E-Mail Address
Name of Person Responsible for Safety Committee		Daytime Telephone Number	E-Mail Address

A. COMMUNICATIONS
If Operating on frequencies licensed by other organizations, list appropriate expiration dates and attach letters of authorization from licensed organization.

1. Submit a list of all on-board medical communications equipment.

2. If initial application, submit copy of FCC license.
   If renewal application, give FCC License expiration dates for all that apply:

   Radio Equipment required under 14CFR part 135: _____

   IHERN: _____

3. Dispatch Method:

   _____Central Dispatch _____ Provider Dispatch _____Other (Explain)_____

B. OPERATIONAL INFORMATION (attach additional pages if necessary)
1. Does your organization provide emergency medical service 24 hours 7 days a week?

   ____Yes ____No If No, explain_____

2. Define Base of Operations and primary and secondary response area.

3. Submit a copy of the F.A.A. Part 135 Operation Specifications Table of Contents Part A and Operations Specification 14 CFR Part 135 (flight minimums)

4. Describe your organization's area-wide plan to provide safety education and to coordinate rotocraft ambulance service with ground EMS organizations, law enforcement, mutual aid back-up systems, and central dispatch when available. (Rotocraft organizations only)

5. List the address for the location where your organization's records are kept.
   _____

6. List any waivers granted to the provider by the EMS Commission. _____

   _____

C. MANPOWER
1. Describe your organization's staffing pattern for air-medical crew and pilots.

2. Provide a listing of all personnel and their qualifications by category:
   List must include all that regularly serve as pilots and air-medical personnel.

D. TRAINING
1. Describe your organization's plan to ensure annual continuing education for air-medical personnel on air transportation problems and flight physiology.

E. VEHICLES

1. Submit a listing of all aircraft to include aircraft type and identification numbers.
   If Initial Application, submit an EMS Commission Vehicle Application for each aircraft.

2. Submit F.A.A. Part 135 Operations Specification part D85, Aircraft Listing.

Submit a copy of the Certificate of Insurance for all aircraft including effective and expiration dates and the amount of coverage.

3. Describe procedures for checking electric and mechanical equipment, medical care equipment, and vehicle integrity.

Disclosure of this information is mandatory. Failure to provide any information may prevent this application from being processed. Misrepresentation of information, failure to comply and maintain compliance with, and/or, violation of any provisions, standards, or requirements may be cause for suspension or revocation. Upon completion, this form will be treated as a public record.

This is to affirm that all statements contained in this application are true to the best of my knowledge. I hereby affirm that I have read and understand the State of Indiana official rules and regulations for Operations and Administration of Emergency Medical Services and agree to strictly adhere to them.

_____

Signature of Chief Executive Officer Date

F. ATTACHMENTS (NO SIGNATURE STAMPS)

1. PROTOCOLS – Submit copy of current protocols, signed and dated by the Medical Director. If a renewal application, submit a letter signed and dated by the Medical Director stating that there have been no changes in the protocols since the previous application. If protocols have changed, submit copies of the changes signed and dated by the Medical Director.
2. MEDICAL DIRECTOR APPROVAL FORM – Submit Form, signed and dated by the Medical Director.
3. PERSONNEL ROSTER – Submit roster, signed and dated by organization CEO and Medical Director.
4. MEDICATIONS – Submit a list of any and all medications and solutions, including amounts, dosages and method of storage, approved and signed by the Medical Director
4. Submit a list of all on-board life support equipment.
5. SUPERVISING HOSPITAL APPROVAL – Submit a letter, signed and dated by the Administrator of Supervising Hospital, listing personnel and affirming that the supervising hospital has reviewed the competency of the ALS personnel and grants them affiliation.
6. CONTRACT – Submit a copy of the contract with the supervising hospital, or interdepartmental memo, if hospital based, or a letter signed and dated by the Administrator of the supervising hospital stating that the existing contract is still in effect. Contract must include detailed descriptions of how the hospital will provide continuing education, medical control, audit and review, liaison and direction for supply of medications and solutions, and safety and survival programs and education.

(Revised 6/2002)